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Why do we need to go beyond just teaching students and trainees in Psychiatry how to pass exams?

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Abstract

With the advent of an increase in foundation programme training posts in psychiatry, this paper looks at how we can maximise this opportunity. Psychiatrists have a role in teaching all undergraduates and foundation year doctors generic skills to become good doctors, but we also have to appeal to and nurture the interests of psychiatrists of the future by maintaining core psychiatric skills/knowledge in our teaching. We also need to tackle the problems of the recruitment crisis to psychiatry and stigma against both our profession and our patients. Medical students and junior doctors are strategic and motivated by passing assessments. However, we are often guilty of gearing our teaching only to this. We also explore the assessment process itself and ways to optimise it. This paper presents a case for going beyond teaching students/ trainees how to pass exams in order to address wider issues relating to psychiatry.

Introduction

With the advent of a much over-due increase in foundation programme training posts in psychiatry, we must seek to make the most of this opportunity, whilst continuing to enhance undergraduate teaching. We need to create good doctors who are highly professional, good communicators and sympathetic to psychosocial needs of all patients. However, we also need to improve recruitment to our own specialty.

Medical students prefer learning general skills rather than specialised ones- this is a 'strategic' outlook that cuts workload (**Kneale 1997**). As a busy foundation year doctor, this problem is further magnified due to the added pressure and responsibility of working and the steep learning curve that comes with this. Students'/ trainees' views must be balanced with the necessity to teach the fundamentals and principles of psychiatry, otherwise the care of the mentally ill will be compromised through lack of knowledge (**Meltzer 1995, Oakley 2008, Davies 2000, Goerg 1999, Williams 1997**). Therefore, psychiatrists have a role in teaching all undergraduates generic skills, such as psychosocial aspects of patient care, and the doctor-patient relationship, with emphasis on professionalism and good communication skills (**Kelly 1991**). However, as well as this, psychiatrists should appeal to and nurture the

interests of psychiatrists of the future by including core psychiatric skills/ knowledge in our teaching (**Ghodse 2004**).

Recruitment

There is a crisis in recruitment in psychiatry. Psychiatry is the least popular clinical specialty amongst medical students, both UK and most countries worldwide (**Sierles 1995, Rajgopal 2004**). 6th form students are often interested in a future career in psychiatry, but something changes during the medical school years (**Maidment 2003**). 3-4% of medical graduates express an interest in psychiatry as a career at the end of training- half the number required to fill consultant posts (but overseas recruitment in UK masks poor recruitment) (**Lambert 2003, Brockington 2002, Maidment 2004**). However, the great variation in medical school contributions to recruitment in psychiatry shows that good teaching can influence recruitment (**Ghodse 2004, Lambert 2003, Ring 1999, Paddock 2013**).

Attitudes to psychiatry significantly improve following teaching programmes (**Glynn 2006, Baxter 2001, Singh 1998**), but this is subject to decay (**Williams 1997, Baxter 2001, Tharyan 2008, Woloshuck 2004, Creed 1987**), with interest in Psychiatry typically falling from 10-11% to 3-4% within 1 year (**Tharyan 2008**). Exposure to non-psychiatric specialties in the final year and focusing on what students think they will need immediately after qualifying are likely reasons (**Williams 1997, Baxter 2001**). Fortunately, psychiatry has started to be included in the foundation years for new doctors, thus increasing exposure (**Goerg 1999, Carey 2000**) and with the recent steps to increase the number of these posts, we have a wonderful opportunity to rectify the problems in recruitment. Quality of teaching is an important 'modifiable' influence on recruitment into psychiatry- especially for those with neutral views beforehand (**Niedermier 2006**). Positive attitudes are promoted by direct patient contact, encouragement from consultants and seeing patients respond well to treatment (**Oakley 2008, McParland 2003, Spiegel 1991**). If more psychiatry could also be taught in the final year, then recruitment might improve further (**Baxter 2001**). However, the creation of the extra foundation posts in psychiatry would be even better.

Yet, there is more to recruitment than just teaching. SNS has personally been ridiculed by other clinicians for being a psychiatrist, "Who would want to deal with 'psychos' by choice?" It was assumed that he had failed in other medical fields and therefore psychiatry was a "last resort," or "to have an easy life as it doesn't take much hard work or brain-power". Unfortunately, criticism or 'bashing' of psychiatry by other specialties is common (**Buchanan 1992, Fink 1983, Holmes 2008**). Psychiatrists are often perceived as unscientific, confused thinkers, emotionally unstable and ineffective (**Buchanan 1992, Fink 1983, Holmes 2008, Duburgas 2007**). They are portrayed negatively in the media (**Fink 1983, Duburgas 2007**). All this has an impact on recruitment by influencing students' perception of psychiatry as a career. It is seen as too slow moving with few clear results/ improvements and ultimately

psychiatrists have low status due to lack of respect shown by other specialties (**Brockington 2002**).

A recent survey examining factors influencing career choices amongst a group of psychiatric trainees and medical students pointed to a powerful role (both positive and negative) of the consultant and role modelling (**Paddock 2013**). Since then, **Shah et al (2015)** has investigated factors influencing career choice in foundation trainees. They identified that foundation programmes could improve recruitment, through trainees working in psychiatry as a field they may not have otherwise considered as a career. This in turn could increase the proportion who chose psychiatry as their top choice of specialty.

Table 1- What influences foundation trainees' career choice (based on Shah et al 2015)

| | |
|-------------------------|---|
| Positive factors | A- Medical student experiences- finding patients interesting, developing an aptitude for the specialty, undergraduate teaching |
| | B- Influence of seniors- role modelling, encouragement, morale |
| | C- Aspects of the work environment- patient contact, general pace of the specialty, team work. |
| Negative factors | A- Perceived poor prognosis of patients; Perceived unscientific basis of psychiatry |
| | B- Negative comments made by other specialties |

A- most influential; B –moderate influence, C- less influential

Stigma

Challenging negative stereotypes regarding psychiatry is a huge motivator for **us** to teach and ensure good clinical practice, thus becoming a 'good ambassador of psychiatry'.

Stigma is a trait which is deeply discrediting (**Goffman 1963**). In psychiatry, it is not just encountered as negative views about psychiatrists themselves, but also against patients. Stigma isn't explicitly addressed in undergraduate teaching, yet we have a duty to tackle it. Stereotyping is an efficient way of structuring knowledge- it is an effective strategy that cuts the cognitive workload, thereby reducing uncertainty related to any novel stimulus (**Hamilton 1979, Townsend 1979**). Therefore, it appeals to strategic students and the problem is magnified due to difficulties in assessing it. The frequency and impact of this stigma is immense, in addition to its negative influence on recruitment.

At least 1 in 4 of us will experience mental illness, but we are all likely to have met someone with mental illness (**MIND 1999**). Stigma (like beauty) is in the eye of the beholder (**Byrne 2000**). Many people get their information about mental illness from the mass media (**Wahl 2004**). Psychiatric disorders, their treatments and those who provide them are all subject to overwhelmingly negative portrayals in the print and broadcast media (**Hyley 1991**).

About 66% of items about mental illness on UK TV focus on violence (**Philo 1996**). More recent international studies have identified themes such as unpredictability, violence, a drain on society and not getting better (**Wilson 1999, Wahl 2004, 2007, Francis 2001, Edney 2004, Schneider 2003**). Many other studies have found a definite connection between negative media portrayals of mental illness and the public's negative attitudes toward people with mental health issues (**Coverdale 2002, Olstead, 2002**). However, **Wahl (1995)** found that this negative media influence also extended to health care professionals.

The public hold negative stereotypes of those with mental illness (**Gray 2002**) - a perception of unfriendliness, inability to function in society, self-infliction and dangerousness (**Purvis 1988**). These attitudes in turn lead to fear, avoidance and discrimination against individuals with mental illness (**Gray 2002, Wahl 2004**). However, self-stigmatisation leads to reduced self-esteem, hopelessness, under-achievement, shame and secrecy which are obstacles to seeking or compliance with treatment (**Phelan 1998, Byrne 2000, Gray 2002**). A MIND survey found that half of the respondents said that the media coverage had a negative effect on their own mental health (**BBC News Online: Health, 2000**), but more worryingly, MIND's 1996 survey on stigma revealed 50% of the mentally ill felt discriminated against by medical services (**Read 1996, Lauber 2006**). Furthermore, doctors with mental illness have high suicide rates, due to denial and delays in seeking treatment due to stigma causing shame (**Gray 2002**).

Stigmatising attitudes develop in early childhood, so are difficult to change. Increased knowledge and contact with the mentally ill challenges negative stereotypes, but one negative image can override the cumulative effects of positive experiences (**Philo 1996, Byrne 2000**). Unfortunately anti-stigma films and campaigns only cause short-term improvements (**Kerby 2008**).

Despite this, we can teach students and trainees in a number of ways in order to reduce stigma. **Byrne (2000)** stated that the starting point to tackle stigma is education. Psychiatrists should acknowledge and address stigma as a separate and important issue in its own right. Service users and carers should be involved in training health-care professionals (**Walters 2007**). The more direct contact that students have with them, the better. A patient's narrative 'normalises' mental illness and allows them to be seen as individuals. Students eventually learn that anyone can develop mental illness if there is enough stress and then this lowers the 'them and us' attitude (**Gray 2002**). Home visits are a way of reducing stigma and trying to understand how a patient lives and behaves in their own environment/ culture/ context (**Dogra 2008, Walters 2007**). Role play is when learners take on the part of patients. It can be a powerful experience that builds empathy and reduces stigma (**McNaughton 2008**).

Salter (2003) recognised that the media are less interested in content, but rather in whether the information is interesting and sustains attention. Therefore, should we be playing the

media at their own game, by making teaching interesting, but with positive images of mental illness and psychiatry (**Edney 2004**)? Due to the growing use of social media and the internet, should we explicitly acknowledge the existence of stigma and prejudice in the media and use of clips (both positive and negative) and encourage healthy discussion and debate in a safe environment? Shouldn't we move with the times and make our teaching more relevant?

Ideal Teaching Practice

Role modelling, particularly of senior clinicians is an important factor which determines career choice and attitudes, so we need to use this to our advantage (**Paddock 2013, Shah 2015**). We need to demonstrate what to do, how to do it and also with the right attitude. Ideal teaching practice should therefore counter-act negative experiences, whilst building on positives. This could be achieved by being enthusiastic about teaching and trying to create a relaxed, positive atmosphere with open questions and discussion- e.g. use of interesting examples based on experience and then selecting specific patients for students to promote experiential learning. A 'thinking aloud approach' might aid decision making and professionalism (**Skoner 2005, Cross 2006**). Giving individualised feedback and also asking for feedback to adapt one's own teaching would continually enhance quality (**Sluijsmans 2003**). A personal narrative explaining what it's like to live the life of a psychiatrist might be an effective way of improving recruitment, as the trainee or student could then picture working in the profession themselves (**Berkhout 2015, Hashmi 2014**).

The essence of teaching ought to be to try to **make students/ trainees feel important**. Foster an environment conducive to learning by avoidance of causing students to feel like a burden- that their learning is interfering with patient care by intruding on privacy and encroaching on a clinician's time. Students/ trainees need to be given certain achievable responsibilities to enable them to feel that they are contributing towards patient care, and thus feel accountable and part of a team. Making juniors feel important, motivates them to learn more than just how to pass assessments by promoting deeper learning and professionalism.

Table 2- Examples of how to make juniors feel important- a strategy for students and the first few weeks of foundation trainee placements

| | |
|--|---|
| <p>Give them responsibility</p> | <ul style="list-style-type: none"> • Allocation of specific patients for students to build rapport and become part of their management and for individualised learning/ personal development • Let them explain things to patients and carers/ families, with senior support. • Allow students to write in notes, provided it is checked and counter-signed • Always give them a task to do- don't let them sit idly at a ward round/clinics or simply become the note-taker without any processing of information (e.g. ask them to observe team dynamics, write the mental state examination or try to work out the management plan.) |
|--|---|

| | |
|--|---|
| Highlight positives of being a junior | <ul style="list-style-type: none"> • Inform students/ trainees that patients often relate better to them as they're not seen as 'part of the system'. • Students are in a unique position in having ample time to build rapport and glean new information. • Patients actually report raised self-esteem and empowerment- feeling useful and important, as someone shows interest and by gaining new insights into their problems (Walters 2003, Black 1998). • Encourage juniors to express their own opinion (untarnished by extensive training), thus providing a fresh approach. |
| Personalise their experience | <ul style="list-style-type: none"> • Give individualised feedback, not just knowledge-based, but body language, communication, attitude, punctuality and appearance (GMC 2002). • Acknowledge the learner's unique autobiography (background/ prior knowledge/ goals) and provide mentorship (Berkhout 2015, Zimmerman 2008, Sandars 2009, Hashmi 2014) • For juniors, do not let service development and day to day clinical work take over certain cases specifically selected for them to enhance their own interest, learning and personal development |

Assessments- Limitations and Solutions

Assessment motivates students to learn, but what should the real aim of teaching be- helping students to pass exams or being a better doctor/psychiatrist (competency + professionalism) (**Cantillon 2006**)? If we are aiming for higher pass rates, we are limited by the validity of assessment (i.e.-whether a test predicts if someone becomes a good doctor). There is often a balance between validity and reliability (**Sweet 2003**) and also between what's ideal and feasible (**Hodges 1999, Van der Vleuten 1996, 2012**). Direct observation of students seeing real patients is valid, but not always practical, hence use of simulated patients (SPs), (**Barrows 1993, Wallace 1997, Schuwirth 2003**). However standardisation of simulation can cause problems (**Cantillon 2006, Sweet 2003, Tamblyn 1994**).

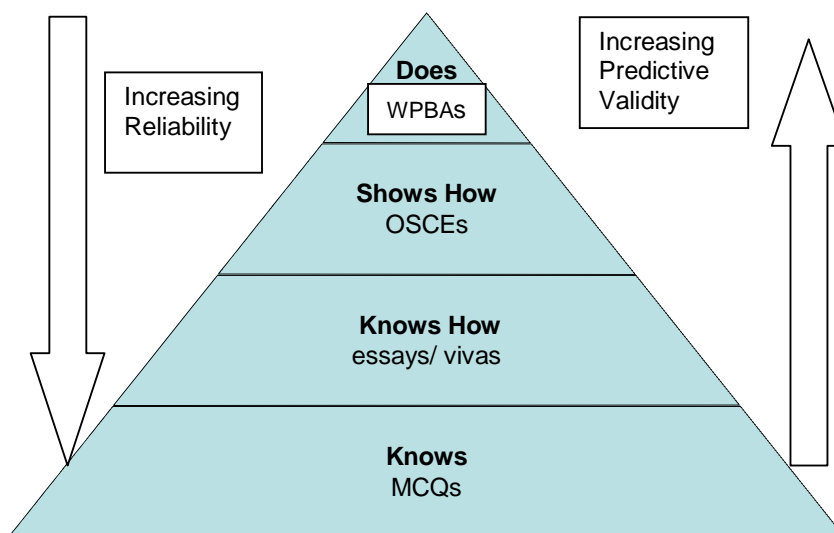


Figure 1- Miller's pyramid- adapted by S.Neil Sarkar 2008 (showing that single assessment often results in a trade-off between reliability and validity).

Miller's Pyramid is a framework for assessing clinical competence (**Miller 1990**). **Norman (2005)** challenged the simplicity of this framework. Various authors have debated its usefulness, as any single assessment (point measurement) implies a compromise on quality criteria (**Van der Vleuten 1996**) as one method can only assess a part of Miller's pyramid (**Van der Vleuten 2012, Hodges 2006, Norman, 2005**). In addition, performance is highly context dependent (**Van der Vleuten 2005**), so any attempt at standardisation will only trivialise the assessment (**Norman 1991**). A single method can't cover all aspects of competencies of the layers of Miller's pyramid, so we need a blend of methods, including professional judgement (**Van der Vleuten 2005**).

A competency is the ability to handle a complex professional task by integrating the relevant cognitive, psychomotor and affective skills (**Van der Vleuten 2005**) and involves knowledge, skills, problem-solving and attitudes (**Frank 2007**). In medicine, it has been defined as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individuals and communities being served" (**Epstein 2002**). Too much emphasis on competence-as-knowledge risks creating 'hidden incompetence'- knowledge smart doctors who had poor interpersonal and technical skills (**Miller 1990, Hodges 2006**).

The psychometric discourse in assessing clinical competence converts human behaviours into numbers (**Hodges 2013**). There has been a tendency to break down competency into smaller units or stable and measurable 'traits' which are assessed separately, with an assumption that the sum of these parts can equate to competent performance in an integrated whole (**Van der Vleuten 2005 Hodges 2013**); but many have criticised this 'over-objectification', 'reductionism' and 'trivialisation' (**Zibrowski 2009, Van der Vleuten 1996 & 2012, Hodges 2006**). Reliability is relevant at the level of individual assessment tools, but not when heterogeneous sources of information are combined (**Hodges 2013**). Should we then be going beyond the psychometric discourse and single assessments of competence?

Table 3- Strategies to Optimise Assessment (based on a review of literature on medical education)

| | |
|------------------------------------|--|
| AIMS | <ul style="list-style-type: none"> Reliable measurements of student/ trainee performance (Epstein 2002, 2007) Predictive validity for subsequent clinical competence (thus aiding decisions about learner progress (Van der Vleuten 2012)) Optimise learning via a formative, educational role (Wass 2001) |
| WHAT TO ASSESS (Epstein) | <ul style="list-style-type: none"> Acquisition and application of knowledge and skills Communication Professionalism Clinical reasoning and judgment in uncertain situations |

| | | |
|---------------|---|--|
| 2007) | <ul style="list-style-type: none"> • Teamwork • Practice-based learning and improvement | |
| IDEAL METHODS | Multi-method | <ul style="list-style-type: none"> • Alleviates the compromises of individual methods (<i>Van der Vleuten 1991, 1996, 2012, Epstein 2002 & 2004, 2007, Wass 2004, Norman 1991</i>). |
| | Triangulation | <ul style="list-style-type: none"> • Integration of competencies for methods that are not as standardised (e.g. oral exams, miniCEX) improves validity (<i>Van der Vleuten 2005</i>) <ul style="list-style-type: none"> • Subjective information assesses complex, ambiguous real-life situations requiring reasoning and judgment. (<i>Van der Vleuten 2012</i>) • Combination of qualitative and quantitative data into a Portfolio comes up with an overall picture (resembles judgement in diagnosis) (<i>Epstein 2007, Van der Vleuten 2005, Driessen 2007</i>) |
| | Improving Validity | <ul style="list-style-type: none"> • Using non-standardised methods- i.e. top of Miller's pyramid (<i>Van der Vleuten 2012</i>). • Involve many assessors and different credible groups (<i>Van der Vleuten 2012</i>) • Utilise raters who know the learner best (coach, peers) (<i>Van der Vleuten 2012</i>) • Using different contexts, to account for complexity of clinical competence (<i>Epstein 2007</i>) • Directs observation of clinical performance where possible (<i>Wass 2001, Pulito 2006</i>) <ul style="list-style-type: none"> • E.g. directly observed long and short cases (<i>Norman 2002</i>), mini-CEX (<i>Norcini 2003a</i>), OSCEs and SPs (<i>Wass 2001</i>). • can be coupled with exercises afterwards, such as oral case presentations, assessment of clinical reasoning, and literature searches (<i>Epstein 2004 & 2007, Anastakis 1991</i>) • Review of videos of encounters to give feedback (<i>Epstein 2004, Leach 2002</i>) |
| | Improving Reliability | <ul style="list-style-type: none"> • Adequate sampling across judges, instruments and contexts (<i>Van der Vleuten 2005, Hodges 2013, Rowntree 1987</i>). • Training assessors and SP standardisation (<i>Van der Vleuten 2012</i>) • Multiple observers/ examiners (<i>Epstein 2007, Wass 2001</i>) • Longer test length (<i>Wass 2001, Hodges 2013</i>) |
| | Longitudinal/ Formative | <ul style="list-style-type: none"> • In an assessment programme, formatively/ over time (<i>Van der Vleuten 2012</i>) • Should be coupled with timely feedback and mentoring to promote <i>learning</i> (<i>Van der Vleuten 2012, Epstein 2007</i>) <ul style="list-style-type: none"> • Narrative information in feedback improves learning (<i>Norcini 2003c, Epstein 2007, Van der Vleuten 2005 & 2012</i>) |
| | Link to Curriculum | <ul style="list-style-type: none"> • Assessments can drive undesirable learning strategies if the assessment is misaligned with curriculum objectives (<i>Al Kadri 2009</i>). • Need to achieve congruence between educational objectives and assessment (<i>Van der Vleuten 2005</i>) |
| | Develop new tools? | <ul style="list-style-type: none"> • Developing tools for the assessment of qualities such as professionalism, teamwork, and expertise that have been difficult to define and quantify thusfar (<i>Epstein 2007, Hodges 2011</i>) |

OSCEs are more reliable and valid than traditional examinations (*Harden 1979, Probert 2003, Hodges 2014, Park 2004, Walters 2005, Vaidya 2008*). Stations involve an SP and examiner and are mainly 7-10 minutes long and scoring is based on a task specific check-list and a global rating scale (*Cantillon 2006*). However, there is still poor correlation between undergraduate competence and postgraduate performance (*Rethans 2002*). This could be due to clinical practice consisting of a range of attributes, hence poor inter-rater reliability (*Wilkinson 2003, Kilminster 2007, Mazor 2007*). Going through a huge checklist in short space of time it is an artificial and high pressure situation, not akin to the day to day assessments a psychiatrist usually undertakes. *Norman (2005)* described, 'shotgun behaviour induced by checklists', leading to hidden incompetence and inappropriate behaviour (*Hodges 2006*). Longer stations (e.g.-OSLER-objective structured long examination record) might overcome the shortcomings of OSCEs by providing more time for reflection and explanation of complex cases and be more akin to real life (*Gleeson 1997, Taghva 2008, Ramchandani 2008, Hodges 2014*). Clinical Assessment of Skills and Competencies (CASC) examination were introduced to postgraduate Psychiatric assessment in June 2008 (*Thompson 2009*) and are more context-rich (*Schuwirth 2004a*) than OSCEs.

A variety of settings and tools would give a fuller picture, but assessment is limited by cost and resources (**Van der Vleuten 2006, 2012**). However, does simply learning to pass exams mean that learning professionalism is overlooked?

In the past (when many of us were undergraduates), more emphasis was put on the lower two levels of Miller's pyramid. OSCEs target the 3rd level, but there have been calls to move assessment back to the real world of the workplace as a result of the development of less standardised, but nevertheless reliable, methods of practice-based assessment (**Van der Vleuten 2005**). Workplace-based assessments (WPBAs) for doctors target the highest level by collecting information in everyday practice, thus improving validity. This is starting to filter down to undergraduates (**Cantillon 2006, Rethans 2002, Wilkinson 2004, Norcini 2003a, 2003b, 2007**) and the 'mini-CEX' is an example for Foundation Trainees (**Ram 1999, Norcini 2003**).

We need to create a smooth transition from student life to professional life, by preparing our students for life as a doctor. They need to know the relevance of factual information rather than becoming bogged down by large volumes of it (**Kneale 1997**). They need consistent role models. In psychiatry, students need to realise what it's actually like to be a psychiatrist and thus make an informed career choice by shadowing more junior doctors (e.g.-on-call). However, this isn't always feasible due to unpredictable clinical settings and the powerful role of consultants as role models has already been mentioned (**Paddock 2003, Shah 2015**).

Professionalism is one's professional identity as a doctor (**Roberts 2005**). It involves 'subordination of one's own interests to those of the patient', i.e.-humanistic values (**Roberts 2005, Swick 1999**). Professionalism (ethics and communication skills) helps doctors make decisions, especially in psychiatry (**GMC 2006, RCPsych 2004**). Psychiatry doesn't have simple tests of physical parameters for diagnosis. You need skills to engage a patient enough to obtain an accurate history- otherwise even vast knowledge won't allow you to make the right decisions. Certain issues of professionalism are particularly important to psychiatry- detaining/treating patients involuntarily, therapeutic alliances, boundaries, confidentiality, consent, capacity, working with the multi-disciplinary team, inter-agency liaison (**RCPsych 2004, American Psychiatric Association 2008**). Some of these can be easily taught/assessed, but some elements are more difficult.

Teaching professionalism is variable due to the complexity of its components and limitation of assessment methods. It is largely through an informal process of modelling (**Joubert 2006**), social constructivism and collaborative learning (**Mazor 2007, Swick 1999, Joubert 2006, Plaire 2002**). More explicit teaching is needed- e.g.-**Simulated patients** (SPs) are actors trained to portray signs and symptoms (**McNaughton 2008**). They can help to standardise assessment, yet add variety to the students' learning experience, by enhancing communication skills in difficult situations- e.g. risk, intrusion, confidentiality (**Barrows 1993**,

Yudkowsky 2002, Birndorf 2002, Dave 2012, Hall 2004, Sadeghi 2007). They provide safety in the face of an unpredictable learning environment. Observation is by facilitators/peers, but can be videotaped for self-reflection (**Ram 1999**). Feedback from SPs, observers and self-reflection are important to effectiveness. **Problem Based Learning (PBL)** uses a clinical problem to stimulate self-directed learning which is then discussed in a group, thus enhancing collaborative learning- important in professionalism (**Cantillon 2006, Sweet 2003**).

The end point in assessments is often seen without an explanation of the route to get there. A 'thinking aloud' approach to the student in everyday clinical scenarios (**Skinner 2005, Cross 2006**) might be a way they understand thought processes via a 'decision-making tree'. Feedback is an essential component of assessment. Feedback should be holistic and not just factual- i.e. commenting on all aspects of professionalism, such as liaising with staff, appearance, dress, punctuality, attitude, legible handwriting and appear interested, enthusiastic and caring. Role-modelling acts as a blue-print or gold standard for comparison (**Joubert 2006, Plaice 2002**). Students and juniors should be encouraged to actively observe/ discuss a clinician's professional behaviour/ interactions with both patients and staff and then to apply what they've learnt. Direct observation of students (e.g. explaining diagnosis/ prognosis/ management) enables individualised feedback on professionalism (**Davies 2000, Ghodse 2004, El-Sayeh 2006**) and ought to form the bulk of the initial part of any placement. This, in conjunction with modelling instils confidence and enhances performance for the rest of the placement and the gains are ultimately far greater than the investment of time and effort in the beginning.

Experienced clinicians rely on a gestalt impression, i.e. pattern recognition and subjective judgement for clinical diagnosis (**Hodges 2013, Epstein 2007**). Therefore, is there a role for holistic supervisor (expert) judgments in assessment, in the form of subjective global impressions over a specific time-frame (**Epstein 2007, Ginsburg 2011, Bogo 2004**)? Diagnostic, contextual, or inter-personal variables might be part of the authentic variability of real practice settings (**Epstein 2007**). Competence is not fixed/ stable, but contextual, constructed, and changeable and also at least partly subjective and collective (**Hodges 2013**). There have been calls for movement away from the purely psychometric model with the re-examination of the value of subjectivity and judgment (**Hodges 2013 & 2006, Epstein 2007, Gingerich 2011**).

However, reliance on subjective information and judgement is seen by many as 'a soft option', biased or unfair (**Van der Vleuten 2012, Hodges 2013**), and therefore less reliable. Various authors have discussed ways of increasing reliability of subjective judgements, such as increased testing time (**Hodges 2013, Wass 2001**); appropriate sampling (**Van der Vleuten 2005**); increasing the number of judgements and the independence and diversity (heterogeneity) of raters and sources of information (**Eva 2012, Surowiecki 2004, Hodges**

2013); and training and performance standards for raters (**Malini Reddy 2010**). However, trying to achieve complete objectification will trivialise the assessment process (**Van der Vleuten 2012**).

General professional competencies are an ability to work in a team, metacognitive skills, professional behaviour, and the ability to reflect/ self-appraise (**Van der Vleuten 2005, Hodges 2011**). Multisource (“360-Degree”) Assessments (**Epstein 2007, Lockyer 2003**) can provide insight into trainees’ work habits, capacity for teamwork, and interpersonal sensitivity (**Ramsey 1993, Dannefer 2005, Violato 1997**) and this is most effective when it includes narrative comments (as well as statistical data), from credible sources, coupled with constructive feedback and mentoring (**Norcini 2003c, Epstein 2007**). An example of how this might apply in practice is to undertake a ‘friends and families test’ as a global/ gestalt impression- i.e. “Would you send your friend or family member to this (future) doctor?” If multiple impressions were collected from a wide range of raters (e.g. from the MDT, patients and peers) and integrated (“jury model”) and narrative feedback was added, this would provide robust and valid information (**Epstein 2007**). If this is coupled with feedback and mentoring, then it will stimulate learning and development (**Driessen 2010, Norcini 2003c, Epstein 2007, Van der Vleuten 2012**).

Assessment of competencies needs to be increasingly based on qualitative, descriptive and narrative information, but the best way forward is to combine this with quantitative, numerical data (**Van der Vleuten 2005**). Integration of competencies for methods that are not as standardised (e.g. oral exams, miniCEX) and using multiple sources of information from various methods to construct an overall judgement by triangulating information across these sources (**Van der Vleuten 2005, Epstein 2002, Harden 2002, Smith 2003**). Moreover, learning is facilitated when tasks are integrated (**Van Merriënboer 1997**) and contextualisation (**Hodges 2006**) (vignette/ problem based learning) enhances validity (**Jozefowicz 2002**). Portfolios and log books are being increasingly used nowadays and include evidence/ documentation of and self-reflection about specific areas of a trainee’s competence (**Carraccio 2004, Snadden 1999, Sweet 2003, Driessen 2007**) and demonstrate professional development (**Epstein 2007**).

In the past, more emphasis was put on summative assessment- (e.g.-end of year exam) favouring strategic learners (**Sweet 2003, Rowntree 1987**), whereas formative assessment encourages deeper learning by providing continuous/ regular feedback, but it’s time-consuming. Timely feedback from assessment enhances learning and identifies students’ strengths and weaknesses (**Sweet 2003, Brown 1994**).

In summary, assessment should use diversity of methods, multi-source feedback (self, peer, patient, carer, staff) and continuous assessment. It should be combined with regular and

meaningful feedback to help students and trainees to learn and improve. Despite this, some elements of professionalism are not captured in exams, but we still have a duty to assess and teach them, especially in psychiatry. With the foundation programme, we need to ensure workplace-based assessments are valid and meaningful, formative and coupled with feedback.

Strategic Learners

Assessment plays a dominant role on student learning (**Marton 1976, Newble 1983, Centeno 2007, Crossley 2002**). However, assessment can have both intended and unintended consequences (**Van der Vleuten 1996**). Negative effect on learning can occur if assessments rely on recall of factual information, thus leading to cramming for exams and stimulating only surface-level learning (**Epstein 2007, Newble 1983**).

Strategic learners are common in medicine. They are motivated (externally) by exams/assessments and might overlook professional values. Given the sheer volume of factual information to process in order to become a doctor, students feel overloaded and become strategic. This often continues into the post-graduate years. To take more interest or study a topic in depth might mean failing something else, so tight is the balance. **Kneale (1997)** explained this growing problem as being due to medical schools becoming larger and thus students feel 'anonymous'. They only attend if they know it will be part of their assessment- i.e. if attendance registers are taken or if a hierarchical figure is present. They prefer exams (i.e. surface learning for short-term recall) rather than continuous assessments (**Kneale 1997**) and only study for the parts of the course that are assessed (**Wass 2001**). Cutting corners means lack of meaningful understanding or change in attitude due to cognitive restructuring. Prejudices regarding psychiatric professionals and patients therefore remain.

There is an egocentric 'classroom' attitude (**Ginsburg 2005**), of learning to satisfy oneself by passing exams or assessments. When you qualify, suddenly you have to know the answers- you can't hide behind the label of 'student'. The emphasis is on patient care/ teamwork, so should we be assessing teamwork and collaboration (**Committee on Quality of Healthcare in America 2001, Lingard 2012**)? A 'true apprenticeship model' (living and working like a junior member of the field) isn't part of undergraduate medical culture. Nursing students get a salary, feel valued/responsible, develop a sense of duty to the team and to patients, thus reducing selfish attitudes and promoting a smooth transition from student to professional. We must aim to improve this situation for students. However, we now have a chance to get this right with the foundation trainees who will indeed have more responsibilities than students and so we need to foster a sense of belonging.

If assessment is to drive learning, it should be formative, produce educational and meaningful information to the learner and be coupled with formative feedback in order to motivate students/ trainees to engage in deeper learning (**Van der Vleuten 2012, Kluger 1996, Hattie 2007, Shute 2008**). Qualitative feedback (narrative information), adds to the meaningfulness of the information (**Sargeant 2010**). We shouldn't simply surrender to strategic learners by emphasising relevance to exams. We ought to go beyond this by considering *Kolb's Experiential Learning Cycle* (**Cross 2006, Kolb 1984**). A learner in a new situation processes their direct experience and new information by self-reflection, comparison with prior experiences/ learning and feedback from others and then a logical theory is established which can then be applied to further experiences by active experimentation and the cycle is repeated. Thus, reflection is used for self-direction- i.e. to plan new learning tasks or goals (**Van Merriënboer 2009, Hodges 2006, Schon 1987, Van der Vleuten 2012**). A clinical teacher should facilitate this integration, by coaching or mentoring (supervision), as reflection is difficult (**Van der Vleuten 2012, Hodges 2006, 2004**). This then promotes progressive levels of deeper learning (**Biggs 1999**). Improving intrinsic motivation is a key factor in overcoming strategic learning and thus promoting deeper learning.

Are we Strategic Teachers?

We can't help thinking that many of us ourselves might be '**strategic teachers**', such is the juggling act we find ourselves in. We face barriers to teaching, such as lack of time, resources, funding and recognition.



Figure 2- Strategic Teachers- how do we fit teaching in?

Are we in essence merely 'good enough' teachers as opposed to good teachers? If so, what example is it setting our students and what impact is it having?

Table 4- Possible impact of 'Strategic Teaching'

| |
|---|
| <p>A) Immediate effects on teaching</p> <ul style="list-style-type: none"> • Poor role models • Generalised feedback given • Poor quality teaching |
| <p>B) Impact on Students</p> <ul style="list-style-type: none"> • Juniors feel unimportant • Lack of motivation for deep learning • Stigma and stereotypes remain |
| <p>C) Long Term Effects to Psychiatry</p> <ul style="list-style-type: none"> • Loss to recruitment into psychiatry • Lack of sympathy/ empathy with psychiatry as future non-psychiatric specialist • Lack of future doctor's confidence in dealing with even basic psychiatric situations/ conditions • Patient suffers • 'Bashing' of psychiatry to next generation of medical students/ foundation trainees • The future of psychiatry suffers! |

Improving Motivation

Motivation can be extrinsic or intrinsic. Strategic learners are motivated extrinsically (e.g.-by assessment). Intrinsic motivation is mediated by student factors (e.g. previous experience, desire to achieve and curiosity to learn) and enhanced by maximising the learning environment, relevance (e.g. immediate needs/ future career) and good teachers (**Markert 2001**).

Maslow's hierarchy of needs explains that non-clinical needs must be met first in order to increase motivation for learning (**Maslow 1943**). Applying this, in essence, is by making the students feel important (i.e. promoting feelings of safety/trust, belonging and self-esteem) as well as attending to their basic physiological needs. However, this can be difficult to attend to lack of facilities in the community and the wards may be chaotic and dangerous (**Parsell 2001**). Therefore, ground rules must be clear and involve mutual respect/ trust. Regular dialogue to ensure a positive learning environment is being met is essential. Pastoral issues must not be neglected (**Cantillon 2006, El-Sayeh 2006**).

Improving motivation is linked to promotion of self-regulated learning (SRL). SRL is a complex and highly individual process (**Sitzmann 2011, Zumbunn 2011**), which is essential for life-long learning as a health-care professional (**Sandars 2009**). Factors known to stimulate SRL

are social support, the opportunity for guided and independent practice, with the support of feedback and stimulation of reflective practice, and the opportunity to make errors and learn from them (**Sitzmann 2011, Berkhout 2015**). It is also influenced by a student's specific goals (**Berkhout 2015, Zimmerman 2008**). It ought to be maximised by offering students more tailored learning opportunities and support based on recognising their needs, personal goals and narrative (**Berkhout 2015, Sandars 2009**). Perhaps this could be aligned to future career aims (**Hashmi 2014**). Conversely, if students cannot relate to external goals set by the curriculum, it will deter SRL (**Berkhout 2015**). Therefore, assessment is the most appropriate engine on which to harness the curriculum (**Wass 2001**). Formative assessments provide benchmarks to orient the learner and reinforce students' intrinsic motivation to learn (**Friedman 2000**). Whereas infrequent summative exams (often at the end of a training block), do not give opportunities to link the results with feedback or inform students' learning needs (**Schuwirth 2004b, 2006**).

The uniqueness of the psychiatric setting should be used to its advantage (**Cantillon 2006, Parsell 2001**). Working within a multi-disciplinary team and utilising patients and carers/relatives enables students to understand different points of view. This is essential to becoming a psychiatrist (**Davies 2000**). 'Hot-seating', to allow students to see patients alone in clinic before seeing them together, enables experiential learning (**Kneale 1997, Kolb 1984**). However, this isn't always feasible, due to time constraints and shortage of rooms. Arranging a mix between general versus specialised and in-patient versus community settings will give students the broadest view of psychiatry with which to make an informed career choice or develop sympathetic attitudes to psychiatry (**Ghodse 2004, Walters 2001**). Home visits are an effective way of reducing stigma (**Walters 2007**). Ward rounds can be made more useful by highlighting teaching points and giving students tasks to keep them active. Smaller groups enhance collaborative learning and team work (**Cantillon 2006, Sweet 2003**) and 1:1 teaching/ feedback is tailor-made/ adaptable and instils enthusiasm, thus enabling modelling (**Cantillon 2006, Sweet 2003, Cross 2006, Parsell 2001**). However, for foundation doctors, they might have less flexibility to visit other services for a broader experience of psychiatry due to the need for service provision. Yet, it is essential to have a longer-term approach and to allow flexibility for a varied experience for then as it ought to improve recruitment to or at least a better understanding of our field.

Teacher's characteristics influence learning and motivation. We were inspired by those who were enthusiastic and caring. Good teachers create an atmosphere where students are motivated by intrinsic drives- identifying with and then modelling enthusiasm (**Markert 2001**). In literature, characteristics of good teachers broadly fall into 2 dimensions:-

| Dimension | Specific Characteristics |
|--|---|
| Ability (<i>Beishuizen 2001</i>)/ | Skills, knowledge, experience (using clear explanations, improvisation, |

| | |
|--|---|
| Cognitive ^(Sutkin 2008) | anecdotes) ^(Markert 2001, Ramsden 2007) . |
| Personality ^(Beishuizen 2001) / Non-cognitive ^(Sutkin 2008) | Humanistic/ interpersonal skills, enthusiastic/ emotionally activating, charismatic, generative, self-aware ^(Ramsden 2007) . Although they are difficult to teach, they need more emphasis in future, as they dominate the literature ^(Sutkin 2008) . |

Table 5- Characteristics of Good Teachers- 2 Dimensions

Conclusion

With the proposed increase in the number of foundation posts in psychiatry in the UK in the near future, we have an excellent opportunity to address problems in psychiatry such as stigma, recruitment and holistic care. However, we need to attend to the basics and turn to the literature on teaching, medical education and psychiatry in order to do this.

We have to motivate students and trainees with good teaching and a variety of methods to promote active learning, thus overcoming the culture of strategic learning. As teachers, we need to be knowledgeable, but humanistic qualities need more emphasis. We must also give and receive regular feedback, adapt to students' needs, maximise the learning environment, and make them feel important. This will improve deeper learning, enhance professionalism, and reduce prejudice. It might even improve recruitment to psychiatry.

More specifically we should try to help promote positive attitudes in all students and juniors, even if they do not want to become psychiatrists. This will then help to address stigma against psychiatrists and also against our patients, but might even influence them to consider psychiatry as a career choice. We must remember that students with neutral views are the most likely to have their attitudes modified by good teaching (**Baxter 2001, Singh 1998**). We should try to identify students showing enthusiasm for psychiatry and should also try to maintain their interest until they make their career choices. This could be achieved by mentoring them longitudinally, involving them in research projects and audits, setting up psychiatry interest groups and campaigning for more exposure to psychiatry in the final undergraduate year. With the advent of an increase in Foundation Training Posts in Psychiatry, we now have an important opportunity to get it right.

Although assessment methods are becoming more valid (and this can be improved further by triangulation of methods), they still don't accurately predict who will become a good doctor. Therefore, we need to teach students to go beyond just passing exams or assessments. Conversely, should we design assessments to better suit our needs in trying to create more holistic doctors or to improve recruitment into psychiatry? Should this be achieved by using

assessment to improve learning and linking it more closely to the curriculum? Is this an issue to tackle by curriculum designers?

Most importantly we should look at ourselves and the examples we set. We, as influential individuals, have a huge bearing on the future of our profession. We must look beyond our own short-term interest and goals and consider the bigger picture.

Multiple Choice Questions

1. ***What is the impact of undergraduate teaching programmes in psychiatry in the short term?***
 - a) Negative attitudes to psychiatry are increased
 - b) Neutral views are enhanced
 - c) Recruitment to psychiatry is increased
 - d) Attitudes to psychiatry improve significantly (T)
 - e) There is not much difference
2. ***In undergraduates with neutral attitudes to psychiatry, what is an important modifiable factor related to improving recruitment in the literature?***
 - a) Quality of teaching (T)
 - b) Variety of learning environment
 - c) Patient exposure
 - d) Multi-disciplinary teaching versus teaching by psychiatrists
 - e) Being taught by junior doctors
3. ***What is the typical rate of decay of initial improvement in attitudes to psychiatry after an undergraduate teaching programme according to a number of sources?***
 - a) Twofold reduction over 3 years
 - b) Threefold reduction over 1 year (T)
 - c) Fivefold reduction over 5 years
 - d) Very little decay over 3 months
 - e) No significant change in 1st year
4. ***What was the phenomenon described by Kneale which creates a barrier for deeper learning and conveying messages beyond exams/ assessment?***
 - a) Experiential learning
 - b) Hierarchy of needs- e.g. self-actualisation
 - c) Stigma against psychiatry
 - d) Strategic students (T)

e) 'Bashing' or belittling of psychiatry by other specialties

5. Which types of characteristics of teachers are gaining increasing importance in educational literature as ways of increasing students' intrinsic motivation to learn (i.e. improving deeper learning)?

- a) Experience
- b) Humanistic/ interpersonal skills (T)
- c) Sound, subject-specific knowledge base
- d) Use of improvisation
- e) A structured approach

Learning Objectives

- 1. Identify the extent of current problems in psychiatry in terms of recruitment and stigma and recognise the role of a psychiatrist in addressing this through teaching.**
- 2. Be aware of impact and limitations of tailoring teaching towards assessment only.**
- 3. Identify ways of improving your own practice in a realistic and practical manner, taking account of the literature and strategies suggested.**

Declaration of Interest

None

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